


**AFFIDAVIT OF  
HESTAL LIPSCOMB**

**EXHIBIT A**

 **CHRISTIANA CARE**  
HEALTH SERVICES

☐ Christiana Hospital    ☒ Wilmington Hospital  
4755 Oglatown-Stanton Rd.    501 W. 14th Street  
Newark, DE 19718    Wilmington, DE 19801

Phone: (302) 733-1900

Date: 4/9/03

Rx # \_\_\_\_\_

Med. Allergies: \_\_\_\_\_

NAME	LIPSCOMB    HESTAL
ADDRESS	REDACTED
MRN	
B.D.	

Circle Refills Limit 1 yr

ONE RX PER BLANK

1    Please excuse Ms. Hestel Lipscomb  
2  
3    from work 4/4/03, and after this  
4    so that she can undergo surgery.  
5    pt may return to work 4/14

NO REFILLS FOR SCHEDULE II DRUGS

AW2401507 -

AT2887175 - GS0100

Resident DEA .... (SUFFIX)

Benjamin Eskra, M.D.

DISPENSE AS WRITTEN



SUBSTITUTION PERMITTED

(SIGNATURE)

EDS II 00034

**AFFIDAVIT OF  
HESTAL LIPSCOMB**

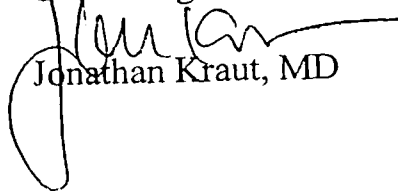
**EXHIBIT B**

To whom it may concern:

04/19/04

Ms. Hestal Lipscomb has been scheduled for outpatient surgery on 4/29/04 at Wilmington hospital. Please contact Surgical Services @ 428-4413 if any question.

Chief Surgical Resident

A handwritten signature in black ink, appearing to read 'Jonathan Kraut', is written over the printed name.

Jonathan Kraut, MD

**Surgical**

**AFFIDAVIT OF  
HESTAL LIPSCOMB**

**EXHIBIT C**



CHRISTIANA CARE  
HEALTH SERVICES

Wilmington Hospital Health Center

Date 5/10/04

Lipscomb, Hospital was seen in  
at the Wilmington Hospital, Surgeon Clinic  
services on \_\_\_\_\_

May return to School/Work on 5/17/04

Remarks: May Return to work  
ON Absence only

Any questions, please call 428 - 4413

16177 P (39371)(0898)

Kram

EDS II 00033

**AFFIDAVIT OF  
HESTAL LIPSCOMB**

**EXHIBIT D**



AT (302) 761-6636  
903-79-2456

DIVISION OF UNEMPLOYMENT INSURANCE

CLAIMANT'S AUTHORIZATION FOR RELEASE OF INFORMATION/  
DOCTOR'S CERTIFICATE

Claimant's Name Hestel Lipscomb **REDACTED**  
Claimant Signature [Signature] Social Security# \_\_\_\_\_

TO THE PHYSICIAN: The claimant's (your patient's) signature on this document authorizes you to respond in writing to the following questions thus constituting a waiver, by the claimant, for this purpose only of the physician-patient privilege. Please be advised that the information requested on this certificate will be used to determine your patient's entitlement to unemployment insurance benefits. Accordingly, it is essential that the information provided on this document be as complete and accurate as possible. Since benefits cannot be paid without this documentation, your timely response is appreciated to avoid delayed payments to your patient. If mailing this form directly to our office would be more expeditious, our mailing address and fax number is listed on the reverse side of this certificate.

- 1. Patient's Name: Hestel Lipscomb has been under my care from 4/7/04 to 5/10/04
- 2. Nature of ailment: **REDACTED**
- 3. prenatal/postnatal care, expected date of childbirth: N/A actual date of childbirth: \_\_\_\_\_
- 4. Was patient advised to quit last job for reasons of health? ☐ Yes ☒ No
- 5. If "Yes", give suggested last date of work: \_\_\_\_\_
- 6. If answer to question 3 is "No", was patient advised to be absent from last job due to health? ☒ Yes ☐ No
- 7. If "Yes", give suggested dates of absence: 4/29/04 - 5/17/04
- 8. Is the patient totally disabled from performing the duties required in his/her current occupation? ☐ Yes ☒ No
- 9. If "Yes", date of disability: from \_\_\_\_\_ to \_\_\_\_\_
- 10. If patient cannot perform regular duties, have/will you permit performance of any other work on a full-time basis? ☒ Yes ☐ No
- 11. If "Yes", specify type of work, together with work limitation, if any: No limitation
- 12. If "Yes", specify date patient was/will be able to perform these duties: 5/18/04
- 13. Comments: \_\_\_\_\_

CERTIFICATION: As a duly authorized practitioner of medicine, I have issued this certificate with full knowledge that it will be used by the Department of Labor to make a determination of eligibility for unemployment insurance benefits under the provisions of Title 19, of the Delaware Code. I certify that the information provided by me is a true representation of the patient's medical condition as it relates to his past employment and/or current state of health.

Physician's Name: Medhi Tadali, MD  
please type or print)  
Physician's Address: Wilmington Hospital Health Center  
Medical Clinic 501 W. 14th St.  
Wilmington, DE 19809  
Office Phone#: (302) 428-4413

[Signature]  
Physician's Signature  
8/12/04  
Date  
Office Fax #: 428-6403



**CERTIFICATE OF SERVICE**

I hereby certify that on this 3<sup>rd</sup> day of July 2006, I caused a copy of the foregoing AFFIDAVIT OF HESTAL LIPSCOMB to be served on the following counsel of record via hand delivery:

Alyssa M. Schwartz, Esquire  
Richards, Layton & Finger, P.A.  
920 King Street, P.O. Box 551  
Wilmington, DE 19899-0551

/s/ Laurence V. Cronin  
Laurence V. Cronin (ID No. 2385)